



QUARTERLY UPDATE TO THE LEGISLATURE

MEDI-CAL MANAGED CARE PROGRAM

**For the Reporting Period
January through March 2012**

**Department of Health Care Services
Medi-Cal Managed Care Division**

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A. PURPOSE OF THE REPORT

Senate Bill (SB) 77 (Committee on Budget and Fiscal Review, Chapter 38, Statutes of 2005), authorized the Department of Health Care Services (DHCS) to expand the Medi-Cal Managed Care program into 13 new counties: El Dorado, Imperial, Kings, Lake, Madera, Marin, Merced, Mendocino, Placer, San Benito, San Luis Obispo, Sonoma, and Ventura.

Since January 1, 2006, DHCS has been required to provide quarterly updates to the policy and fiscal committees of the Legislature on DHCS' core activities to improve the Medi-Cal Managed Care program and to expand into the 13 new counties.

Pursuant to SB 77, the quarterly updates shall include:

- Progress or key milestones and objectives to implement changes to the existing program;
- Submittal of State Plan Amendments to the Centers for Medicare and Medicaid Services;
- Submittal of any federal waiver documents; and
- Applicable key functions related to the effort to expand the Medi-Cal Managed Care program.

In response to legislative inquiries on the risk-adjusted capitation rate setting methodology, DHCS added this information into the quarterly update report.

This report is not intended to update the ongoing development and implementation of the Section 1115 Demonstration Waiver authorized under Assembly Bill (AB) X4 6 (Evans, Chapter 6, Statutes of 2009). Updates regarding the Section 1115 Demonstration Waiver are included in the semi-annual report titled "Mandatory Enrollment of Seniors and Persons with Disabilities into Medi-Cal Managed Care."

DHCS is currently undertaking or has completed the actions listed below to enhance and improve the Medi-Cal Managed Care Program. The following report is a condensed version of previous reports and highlights the changes or additions from the previous report which are shown in italics for emphasis.

B. AVOIDABLE EMERGENCY ROOM VISITS COLLABORATIVE

DHCS has worked collaboratively with Medi-Cal managed care health plans to reduce avoidable visits to the emergency room (ER) for the past four years. An avoidable ER visit is a visit that is more appropriately managed by and/or referred to a primary care provider through an office or clinic setting. Health plans worked collaboratively to

implement two statewide interventions: a health education campaign and a health plan collaboration with a selected network hospital.

The ER Collaborative ended in December 2010 and all health plans submitted their final ER Collaborative reports to the External Quality Review Organization (EQRO). The EQRO is in the process of reviewing these reports. A final Statewide ER Collaborative report is targeted for release in the Fall of 2012. The report will summarize the successes, challenges, and lessons learned to reduce avoidable ER visits during the past four years.

C. REDUCING HOSPITAL READMISSIONS

On July 21, 2011, DHCS had a Kick Off meeting with Medi-Cal managed care health plans and the EQRO to begin a new collaborative: reducing hospital readmissions. Two subcommittees were formed during this meeting: the Guiding Principles subcommittee; and the Measure Specifications subcommittee. Both subcommittees were composed of staff from the Medi-Cal Managed Care Division (MMCD), health plans, and the EQRO.

The Guiding Principles subcommittee developed and finalized the guiding principles for the Reducing Hospital Readmissions collaborative. A hospital readmission is a preventable or avoidable hospital admission that occurs within 30 days after discharge from the first or index admission. Health plans submitted Reducing Hospital Readmissions collaborative Quality Improvement Project (QIP) proposals on March 30, 2012. Health plans' objective for the next three years is to work collaboratively to understand the reasons why Medi-Cal members 21 years of age and older are readmitted and identify effective strategies to reduce hospital readmission rates. The Measure Specifications subcommittee reviewed and finalized the Healthcare Effectiveness Data and Information Set (HEDIS) measures specific to the Medicaid population.

D. ASSEMBLY BILL 1422 GROSS PREMIUMS TAX SUNSET EXTENSION

AB 1422 (Bass, Chapter 157, Statutes of 2009) added Medi-Cal managed care health plans to the list of insurers subject to California's gross premiums tax, or Managed Care Organization tax, a 2.35 percent tax on total operating revenue. The proceeds from this tax are appropriated to DHCS for the Medi-Cal Managed Care program and to the Managed Risk Medical Insurance Board for the Healthy Families program (HFP). The bill increases premiums paid by HFP enrollees, and allows the California Children and Families Commission to transfer monies among its various funds.

The bill took effect retroactively to January 1, 2009 and was scheduled to sunset on January 1, 2011. SB 208 (Steinberg, Chapter 714, Statutes of 2010) extended the sunset date of AB 1422 to June 30, 2011. State Budget health trailer bill ABX1 21 (Blumenfield, Chapter 11, Statutes of 2011) extended the sunset date again from June 30, 2011 to June 30, 2012. *DHCS is currently proposing trailer bill language to eliminate the sunset date altogether.*

E. RISK-ADJUSTED CAPITATION RATES

For rate years beginning in State Fiscal Year 2009-10, DHCS implemented maternity supplemental payments and risk-adjusted capitation rates for health plans contracting in counties that provide health care under the Two-Plan and Geographic Managed Care models of managed care. The maternity supplemental payments to health plans were in addition to monthly capitation payments and were based on health plan reports of delivery events.

Capitation rates were risk-adjusted to match each health plan's projected costs to their capitated payments more effectively. To calculate the final capitation rates, the final risk-adjusted scores were applied to the developed county average capitation rates. For the first and second years, risk-adjustments were phased in using a rate comprised of 20 percent risk-adjusted county average rates and 80 percent plan-specific rates. For the third year, risk-adjustments are being phased in using a rate comprised of 25 percent risk-adjusted county average rates and 75 percent plan-specific rates. *For the fourth year, risk-adjustments will be phased in using a rate comprised of 35 percent risk-adjusted county average rates and 65 percent plan-specific rates.*